DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 — 0 0 2

2. STATE: Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447, Sub Part C

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ (405,523)
b. FFY 2005 $ (594,740)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Appendix I
Page 2-2j

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Appendix I
Page 2-2j

10. SUBJECT OF AMENDMENT:
Elminates Non-state Public Nursing Facility Adjustment

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Roy Jeffus

14. TITLE:
Director

15. DATE SUBMITTED:
February 17, 2004

16. RETURN TO:
Division of Medical Services
P. O. Box 1437
Little Rock, AR 72203-1437

Attention: Joie Wallis
Slot S295

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: FEB 23 2004

18. DATE APPROVED: MAR - 2 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

8. Non-State Public Nursing Facility Adjustment

~~Effective February 21, 2002, a non-state public nursing facility (that is, a public nursing facility that is not owned or operated by the State of Arkansas) shall qualify for a monthly reimbursement adjustment. The adjustment shall result in total payments to the public nursing facilities that are equal to but not in excess of the total of each individual facility's Medicare-related upper payment limit. The public nursing facility with the greatest number of Medicaid days by date of service from the previous state fiscal year will receive the adjustment. The adjustment shall be calculated as follows:~~

~~Once a year:~~

~~1.All Minimum Data Set (MDS) submissions for the previous state fiscal year for Medicaid residents by public nursing facility will be processed through the Medicare 44-group RUG classification system to attain the RUG score.~~

~~2.A report will be generated by facility identifying all prescription drugs, lab and x-ray paid by Medicaid for Medicaid residents. Total cost will be divided by twelve to derive a monthly amount.~~

~~3.A report will be generated by facility identifying Medicaid resident days for the previous fiscal year. Total days will be divided by twelve to derive a monthly amount.~~

~~Monthly:~~

~~1.The current Medicare rate associated with each RUG score will be assigned as if the resident were Medicare.~~

~~2.An average rate will be calculated by facility from all rates determined above.~~

~~3.The difference in a facility's average Medicare rate and the facility's Medicaid rate is calculated.~~

~~4.This difference is multiplied by the number of monthly Medicaid resident days.~~

~~5.The monthly amount of prescription drugs, lab and x-ray charges will be subtracted from the product calculated in step 4 by facility.~~

~~6.The total UPL amount is the sum of the amounts calculated in step 5.~~

~~7.Payment shall be made on a monthly basis by the fifteenth of the month.~~

Effective January 1, 2004, the Non-State Public Nursing Facility Adjustment is eliminated.

STATE ARKANSAS
DATE REC'D 2-23-04
DATE APPV'D 3-2-04
DATE EFF 1-1-04
HCFA 179
A